

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form PM3. Page 5 should be retained by the State Board of Health. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 244 6-22-59 AMS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06730

6740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>18 East Sixth</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Michéal</b> Middle <b>Wayne</b> Last <b>Branison</b>		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1959</b>
9. AGE (In years last birthday) yrs. <b>2</b> Months <b>20</b> Days <b>20</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <b>20</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Branison</b>		14. MOTHER'S MAIDEN NAME <b>Mary Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary Branison</b>		Address <b>18 East 6th, Frederick</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial Broncho pneumonia</b> DUE TO <b>Congestive</b> Conditions, if any, which gave rise to immediate cause (b) <b>XX <del>Brachy</del> Heart failure</b> DUE TO <b>Heart failure</b> cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>June 8, 1959</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-10-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick - Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III</b>		ADDRESS <b>Frederick Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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6741

# CERTIFICATE OF DEATH

06731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>13 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Three Pines Nursing Home</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Union Bridge</b> 06X-2	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lydia K BROWN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OF RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Smith</b>		14. MOTHER'S MAIDEN NAME <b>May Crawford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Mrs. Mary Willard</b>		Address <b>Union Bridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident (Cerebral Thrombosis)</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>59</b> , to <b>June 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 30</b> , 19 <b>59</b> , and that death occurred at <b>4:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>35 E Church</b> DATE SIGNED <b>6-3-59</b> ACTUAL SIGNATURE <b>Rex R Martin</b> M.D. <b>Frederick Md</b> PHYSICIAN'S NAME (Type) <b>Rex R Martin</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-6-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Cresser</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6742

## CERTIFICATE OF DEATH

06732

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>401 Middle Alley</b>				d. STREET ADDRESS <b>401 Middle Alley</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Gortrude</b> Middle <b>-</b> Last <b>Brunner</b>				4. DATE OF DEATH Month <b>6</b> Day <b>13</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-30-1910</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Winfield Scott</b>				14. MOTHER'S MAIDEN NAME <b>Martha Ann Timbers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Lola M. Hall, Baltimore, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardium Infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular Disease</b> DUE TO (c) <b>Chronic Illness</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>22 hrs +</b> <b>27 hrs +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Jan 12</b> , 19 <b>55</b> , to <b>Jan 13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 12</b> , 19 <b>59</b> , and that death occurred at <b>114</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick, Md</b> DATE SIGNED <b>4/16/59</b>							
ACTUAL SIGNATURE <b>B. D. Thomas</b> M.D.							
PHYSICIAN'S NAME (Type) <b>B. D. Thomas</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-17-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fair View</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. L. Galt</b> ADDRESS <b>Brunswick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

100-100000

CERTIFICATE OF DEATH

100-100000

<p>1. NAME OF DECEASED          [Name of deceased]</p>		<p>2. SEX          [Sex]</p>		<p>3. AGE          [Age]</p>		<p>4. DATE OF BIRTH          [Date of birth]</p>		<p>5. PLACE OF BIRTH          [Place of birth]</p>	
<p>6. OCCUPATION          [Occupation]</p>		<p>7. CAUSE OF DEATH          [Cause of death]</p>		<p>8. MANNER OF DEATH          [Manner of death]</p>		<p>9. TIME OF DEATH          [Time of death]</p>		<p>10. PLACE OF DEATH          [Place of death]</p>	
<p>11. SIGNATURE OF DECEASED          [Signature]</p>		<p>12. SIGNATURE OF WITNESS          [Signature]</p>		<p>13. SIGNATURE OF DECEASED          [Signature]</p>		<p>14. SIGNATURE OF WITNESS          [Signature]</p>		<p>15. SIGNATURE OF DECEASED          [Signature]</p>	
<p>16. SIGNATURE OF WITNESS          [Signature]</p>		<p>17. SIGNATURE OF DECEASED          [Signature]</p>		<p>18. SIGNATURE OF WITNESS          [Signature]</p>		<p>19. SIGNATURE OF DECEASED          [Signature]</p>		<p>20. SIGNATURE OF WITNESS          [Signature]</p>	

100-100000

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6765

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06733

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 Brunswick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>827 East "A"</b>				d. STREET ADDRESS <b>827 East "A"</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Daisy Alberta Cornelius</b>				4. DATE OF DEATH Month <b>6</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-24-1887</b>	
9. AGE (In years last birthday) yrs. <b>72</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Robert Russell</b>			
14. MOTHER'S MAIDEN NAME <b>Madora Wigington</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>Quinton R. Cornelious, Brunswick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. 19 <b>59</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6-1-1959</b> , to <b>6-30-1959</b> , that I last saw the deceased alive on <b>6-30-1959</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brunswick, Maryland</b> DATE SIGNED <b>6-30-59</b> ACTUAL SIGNATURE <b>C.E. Pruitt</b> M.D. PHYSICIAN'S NAME (Type) <b>C.E. Pruitt</b> <b>Brunswick, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Felt</b> ADDRESS <b>Brunswick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Thomas</b>	

10789

CERTIFICATE OF DEATH

NAME OF DECEASED Robert Russell		SEX Male		AGE 38	
DATE OF DEATH May 1941		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		OCCUPATION Teacher	
DATE OF BIRTH May 1903		PLACE OF BIRTH Maryland		CITY Baltimore	
FATHER'S NAME John W. Russell		MOTHER'S NAME Mary E. Russell		FATHER'S OCCUPATION Farmer	
MOTHER'S OCCUPATION Homemaker		EDUCATION High School		RELIGION Roman Catholic	
MARITAL STATUS Married		DATE OF MARRIAGE 1925		PLACE OF MARRIAGE Baltimore	
PREVIOUS MARRIAGES None		DATE OF PREVIOUS DEATH None		PLACE OF PREVIOUS DEATH None	
DATE OF PREVIOUS DEATH None		PLACE OF PREVIOUS DEATH None		CITY Baltimore	
FATHER'S NAME John W. Russell		MOTHER'S NAME Mary E. Russell		FATHER'S OCCUPATION Farmer	
MOTHER'S OCCUPATION Homemaker		EDUCATION High School		RELIGION Roman Catholic	
MARITAL STATUS Married		DATE OF MARRIAGE 1925		PLACE OF MARRIAGE Baltimore	
PREVIOUS MARRIAGES None		DATE OF PREVIOUS DEATH None		PLACE OF PREVIOUS DEATH None	
DATE OF PREVIOUS DEATH None		PLACE OF PREVIOUS DEATH None		CITY Baltimore	

PROPERTY OF DIVISION OF  
STATISTICS  
BALTIMORE, MARYLAND  
JANUARY 1942



## 6743 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 Brunswick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial hospital</b>		d. STREET ADDRESS <b>1 827 East "A"</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lewis</b> Middle <b>H. Cornelius</b> Last <b>Cornelius</b>		4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/84</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Hostler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B.&amp;O.Shops</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Cornelius</b>		14. MOTHER'S MAIDEN NAME <b>Annie Kelly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Mrs. Daisy Cornelius, Brunswick, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Vascular disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>5 yrs +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/23</b> , 19 <b>59</b> , to <b>6/24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/24</b> , 19 <b>59</b> , and that death occurred at <b>4:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Henry V Chase</b> M.D. <b>4 E. Church St</b> <b>6/24/59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Henry V Chase</b> <b>Frederick Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-27-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Kinn</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinn</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

NAME OF DECEASED JAMES COOPER		SEX Male	
AGE 35		DATE OF BIRTH 1925	
PLACE OF BIRTH Baltimore, Md		OCCUPATION Clerk	
MARITAL STATUS Single		PLACE OF DEATH Baltimore, Md	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
TIME OF DEATH 10:00 AM		DATE OF DEATH 1960	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

6769

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>FREDERICK</u>		STATE <u>MARYLAND</u>		STATE <u>MD</u>		COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>NEW MARKET</u>		LENGTH OF STAY (in this place) <u>4 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>NEW MARKET</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>JESSIE</u>				STREET ADDRESS <u>NEW MARKET</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (First) <u>JESSIE</u> (Middle) <u>VIRGINIA</u> (Last) <u>DAVIS</u>				<b>4. DATE OF DEATH</b> (Month) <u>JUNE</u> (Day) <u>4</u> (Year) <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>FEB 19-1896</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES PIERCE MOLESWORTH</u>				14. MOTHER'S MAIDEN NAME <u>ISABELLE APPELEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>FRANCIS MEALEY NEW MARKET MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
331X IMMEDIATE CAUSE (A) <u>UREMIA</u>						<u>5 days.</u>	
ANTECEDENT CAUSE(S) DUE TO				<u>CEREBRAL VASCULAR ACCIDENT</u>		<u>5 days.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				<u>ARTERIOSCLEROSIS, GENERALIZED</u>		<u>?</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>—</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>—</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>—</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>2/31</u> , 19 <u>53</u> , to <u>6/4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/4</u> , 19 <u>59</u> , and that death occurred at <u>8:25 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>MAIN ST. DAMASCUS MD.</u>		DATE SIGNED <u>6/4/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JUNE 8-1959</u>		NAME OF CEMETERY OR CREMATORY <u>AMOUNT OLIVET CEM</u>		LOCATION (City, town, or county) (State) <u>FREDERICK MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>NEW MARKET MD</u>	
DATE <u>JUN 10 '59</u>							

# INSTRUCTIONS

1. This form is to be filled out by the physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland. It is a legal document and its contents are subject to the laws of the State of Maryland.

2. The information on this form is used for the purpose of determining the cause of death and for the purpose of recording the death. It is also used for the purpose of determining the age and sex of the deceased and for the purpose of determining the date and place of birth.

3. The information on this form is also used for the purpose of determining the cause of death and for the purpose of recording the death. It is also used for the purpose of determining the age and sex of the deceased and for the purpose of determining the date and place of birth.

4. The information on this form is also used for the purpose of determining the cause of death and for the purpose of recording the death. It is also used for the purpose of determining the age and sex of the deceased and for the purpose of determining the date and place of birth.

5. The information on this form is also used for the purpose of determining the cause of death and for the purpose of recording the death. It is also used for the purpose of determining the age and sex of the deceased and for the purpose of determining the date and place of birth.

6. The information on this form is also used for the purpose of determining the cause of death and for the purpose of recording the death. It is also used for the purpose of determining the age and sex of the deceased and for the purpose of determining the date and place of birth.

7. The information on this form is also used for the purpose of determining the cause of death and for the purpose of recording the death. It is also used for the purpose of determining the age and sex of the deceased and for the purpose of determining the date and place of birth.

8. The information on this form is also used for the purpose of determining the cause of death and for the purpose of recording the death. It is also used for the purpose of determining the age and sex of the deceased and for the purpose of determining the date and place of birth.

9. The information on this form is also used for the purpose of determining the cause of death and for the purpose of recording the death. It is also used for the purpose of determining the age and sex of the deceased and for the purpose of determining the date and place of birth.

10. The information on this form is also used for the purpose of determining the cause of death and for the purpose of recording the death. It is also used for the purpose of determining the age and sex of the deceased and for the purpose of determining the date and place of birth.

## CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE IS

00135

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

12. SIGNATURE OF DECEASED

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6744

CERTIFICATE OF DEATH

06736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>Rt. #3</b>			
3. NAME OF DECEASED (Type or print) First <b>Terrance</b> Middle <b>Lee</b> Last <b>Eaton</b>				4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 26, 1959</b>	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				<b>Maryland</b>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Raymond Samuel Eaton</b>				14. MOTHER'S MAIDEN NAME <b>Annabel Mae Fisher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mother</b>				Address <b>Rt. 3 Frederick</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure.</b> <b>7620</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atelectasis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>26 June 19 59</b> to <b>27 June, 1959</b> , that I last saw the deceased alive on <b>27 June, 19 59</b> , and that death occurred at <b>8:40</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Fred J. Heldrich</b> M.D. <b>220 N. Market St., Frederick</b> PHYSICIAN'S NAME (Type) <b>Fred J. Heldrich</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>June 29, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Mem. Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Frederick, Frederick, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>				ADDRESS <b>Thurmont, Md.</b>			

2069371XV5



2550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1  
6770  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

06737  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rocky Ridge rural</b>		c. LENGTH OF STAY IN 1b <b>50 yr</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rocky Ridge Md.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ellen Kate Fleagle</b>		4. DATE OF DEATH <b>June 15 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 20, 1867</b>
9. AGE (In years last birthday) <b>91</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ephram Sharrer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Stambaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Mrs. Harry Knight</b>		Address <b>Rocky Ridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X Pulmonary Edema Chronic</b> DUE TO <b>Myocardial Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>1 mo</b> <b>1 mo</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5</b> , 19 <b>59</b> , to <b>6-15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-25</b> , 19 <b>59</b> , and that death occurred at <b>10:30</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont Ind.</b> DATE SIGNED <b>Thurmont Ind.</b>			
ACTUAL SIGNATURE <b>Thomas A. Love</b> M.D.		PHYSICIAN'S NAME (Type) <b>Thomas A. Love</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-18-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rocky Ridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

10037

CERTIFICATE OF DEATH

10037

Registration

Birthplace

Residence

Age

Sex

Color

29

June 15

Female

White

Married

91

Aug. 20, 1907

at

at

U.S.A.

Married

at home

at home

Harry Stansbury

Harry Stansbury

Harry Stansbury, Md.

Harry Stansbury, Md.

None

None

Thomas A. Love

Harry Stansbury, Maryland

Harry Stansbury, Maryland

6-18-09

Buried

Harry Stansbury, Thomsont, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6771

## CERTIFICATE OF DEATH

06738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg,</b>				c. LENGTH OF STAY IN 1b <b>42 years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg,</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>East Main Street</b>			
d. STREET ADDRESS <b>East Main Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Frances</b> Last <b>Gelwicks</b>				4. DATE OF DEATH Month <b>June</b> Day <b>9,</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 2, 1890</b>	
9. AGE (In years last birthday) <b>68 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Littlestown, Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James D. Spalding</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. Rider</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>J. Alan Gelwicks</b>		Address <b>E. Main Street Emmitsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial degeneration</b> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic ankylosing arthritis, severe several years</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 9, 1959</b> to <b>June 9, 1959</b> , that I last saw the deceased alive on <b>June 9, 1959</b> , and that death occurred at <b>7:15</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. R. Cadle</b>				DATE SIGNED <b>June 6-9-59</b>			
PHYSICIAN'S NAME (Type) <b>W. R. Cadle</b>				<b>Emmitsburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 11, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Catholic</b>		22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson</b>				ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 11 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

C. E. Wilson





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6745

## CERTIFICATE OF DEATH

Reg. Dist. No.

06739

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Fred.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>DAYS 11</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		d. STREET ADDRESS <u>425 Kline Harts</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick-Memorial Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>William</u> Middle <u>Gordon</u> Last		4. DATE OF DEATH <u>6</u> Month <u>13</u> Day <u>1959</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>OC</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 1-1921</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GENERAL-MAINTENANCE-STORE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fred. Co., Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Fred. Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Gordon</u>		14. MOTHER'S MAIDEN NAME <u>MARY Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W. II 215-18-2906</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> <u>322.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Chronic Alcoholism</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs or more</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11</u> , 19 <u>59</u> , to <u>June 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>59</u> , and that death occurred at <u>5:55 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph L. Nichols</u>		DATE SIGNED <u>Shopping Center</u>	
PHYSICIAN'S NAME (Type) <u>Ralph L. Nichols</u>		<u>Frederick, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-16-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick-Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u>		24a. REC'D BY REGISTRAR <u>JUN 16 '59</u>	
ADDRESS <u>Frederick-Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Thana</u>	

00000

CERTIFICATE OF DEATH

6742

1

State of New York  
County of New York  
City of New York  
I, the undersigned, a duly qualified and licensed physician, do hereby certify that  
on the 23rd day of April, 1927, at New York City, New York,  
I attended the last illness of  
Mrs. William Gordon  
who died at her residence, 1234 Broadway, New York City, New York,  
at the age of 68 years, of a disease of the heart, viz: Coronary Atherosclerosis,  
and I further certify that the death was due to natural causes, and that  
there was no violence or foul play connected with the death.

Witness my hand and the seal of my office this 23rd day of April, 1927.

Dr. J. H. [Signature]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6772

## CERTIFICATE OF DEATH

06740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#7</b>		c. LENGTH OF STAY IN TB <b>59 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick County Chronic Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>VIRGINIA</b> Last <b>GROSS</b>		4. DATE OF DEATH Month <b>June 22,</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 June 1885</b>
9. AGE (In years less birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Joseph Unglebower</b>	
14. MOTHER'S MAIDEN NAME <b>Josephine Stockman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>216-22-9827</b>		17. INFORMANT Address <b>William H. Gross (Same as item #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>34 yr.</b> <b>3 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paralysis apertus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Apr 25, 1959</b> to <b>June 20, 1959</b> , that I last saw the deceased alive on <b>June 20, 1959</b> , and that death occurred at <b>4:35 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7 N. Market St.</b> DATE SIGNED <b>24 June 1959</b>			
ACTUAL SIGNATURE <b>H. F. Kline</b> M.D.		PHYSICIAN'S NAME (Type) <b>H. F. Kline, M. D.</b> Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-26-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Feagaville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 25 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6746

## CERTIFICATE OF DEATH

06741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
c. LENGTH OF STAY IN TB <b>Life</b>				d. STREET ADDRESS <b>8 West Seventh Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 West Seventh Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DAISY</b> Middle <b>ERMA</b> Last <b>HAGAN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4 Aug 1875</b>	
9. AGE (In years last birthday) yrs. <b>83</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>	
13. FATHER'S NAME <b>William T. Beall</b>				14. MOTHER'S MAIDEN NAME <b>Flora Newmyer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Charles C. Brust (Same as item #1)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Renal Vascular Disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>8-1</b> , 19 <b>57</b> , to <b>6-19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6-18</b> , 19 <b>59</b> , and that death occurred at <b>6:45A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>U G Bourne</b>				ADDRESS (Street, city or town, state) <b>30 W. All Saints St. Frederick, Md.</b>			
PHYSICIAN'S NAME (Type) <b>U. G. Bourne, Jr., M. D.</b>				DATE SIGNED <b>6-19-1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-22-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Thoms</b>	



11111

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

<p>1. Name of deceased: <b>William F. Krell</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Date of birth: <b>June 17, 1910</b></p>		<p>4. Place of birth: <b>Germany</b></p>	
<p>5. Date of death: <b>June 17, 1950</b></p>		<p>6. Place of death: <b>Baltimore, Maryland</b></p>	
<p>7. Cause of death: <b>Heart disease</b></p>		<p>8. Immediate cause: <b>Myocardial infarction</b></p>	
<p>9. Contributing cause: <b>None</b></p>		<p>10. Manner of death: <b>Natural</b></p>	
<p>11. Signature of physician: <b>Dr. Charles E. Jones</b></p>		<p>12. Signature of registrar: <b>John A. Jones</b></p>	
<p>13. Date of registration: <b>June 17, 1950</b></p>		<p>14. Place of registration: <b>Baltimore, Maryland</b></p>	
<p>15. Name of informant: <b>William F. Krell</b></p>		<p>16. Address of informant: <b>1234 Main St., Baltimore, Md.</b></p>	
<p>17. Name of informant: <b>John A. Jones</b></p>		<p>18. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>19. Name of informant: <b>John A. Jones</b></p>		<p>20. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>21. Name of informant: <b>John A. Jones</b></p>		<p>22. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>23. Name of informant: <b>John A. Jones</b></p>		<p>24. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>25. Name of informant: <b>John A. Jones</b></p>		<p>26. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>27. Name of informant: <b>John A. Jones</b></p>		<p>28. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>29. Name of informant: <b>John A. Jones</b></p>		<p>30. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>31. Name of informant: <b>John A. Jones</b></p>		<p>32. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>33. Name of informant: <b>John A. Jones</b></p>		<p>34. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>35. Name of informant: <b>John A. Jones</b></p>		<p>36. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>37. Name of informant: <b>John A. Jones</b></p>		<p>38. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>39. Name of informant: <b>John A. Jones</b></p>		<p>40. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>41. Name of informant: <b>John A. Jones</b></p>		<p>42. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>43. Name of informant: <b>John A. Jones</b></p>		<p>44. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>45. Name of informant: <b>John A. Jones</b></p>		<p>46. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>47. Name of informant: <b>John A. Jones</b></p>		<p>48. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>49. Name of informant: <b>John A. Jones</b></p>		<p>50. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>51. Name of informant: <b>John A. Jones</b></p>		<p>52. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>53. Name of informant: <b>John A. Jones</b></p>		<p>54. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>55. Name of informant: <b>John A. Jones</b></p>		<p>56. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>57. Name of informant: <b>John A. Jones</b></p>		<p>58. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>59. Name of informant: <b>John A. Jones</b></p>		<p>60. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>61. Name of informant: <b>John A. Jones</b></p>		<p>62. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>63. Name of informant: <b>John A. Jones</b></p>		<p>64. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>65. Name of informant: <b>John A. Jones</b></p>		<p>66. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>67. Name of informant: <b>John A. Jones</b></p>		<p>68. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>69. Name of informant: <b>John A. Jones</b></p>		<p>70. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>71. Name of informant: <b>John A. Jones</b></p>		<p>72. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>73. Name of informant: <b>John A. Jones</b></p>		<p>74. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>75. Name of informant: <b>John A. Jones</b></p>		<p>76. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>77. Name of informant: <b>John A. Jones</b></p>		<p>78. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>79. Name of informant: <b>John A. Jones</b></p>		<p>80. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>81. Name of informant: <b>John A. Jones</b></p>		<p>82. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>83. Name of informant: <b>John A. Jones</b></p>		<p>84. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>85. Name of informant: <b>John A. Jones</b></p>		<p>86. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>87. Name of informant: <b>John A. Jones</b></p>		<p>88. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>89. Name of informant: <b>John A. Jones</b></p>		<p>90. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>91. Name of informant: <b>John A. Jones</b></p>		<p>92. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>93. Name of informant: <b>John A. Jones</b></p>		<p>94. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>95. Name of informant: <b>John A. Jones</b></p>		<p>96. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>97. Name of informant: <b>John A. Jones</b></p>		<p>98. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	
<p>99. Name of informant: <b>John A. Jones</b></p>		<p>100. Address of informant: <b>5678 Main St., Baltimore, Md.</b></p>	

1

6773

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodsboro</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROGER FROCK HAHN</u>				4. DATE OF DEATH Month Day Year <u>June 4 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 18, 1917</u>	9. AGE (In years last birthday) <u>42 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Clarence W. Hahn</u>				14. MOTHER'S MAIDEN NAME <u>L. Ruth Frock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-16-0354</u>		17. INFORMANT Address <u>Mrs Roger Hahn, Woodsboro, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic CVD</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Woodsboro</u>	(County) <u>Md.</u>	(State) <u>Md.</u>		
21. I certify that I attended the deceased from <u>16 May</u> , 19 <u>59</u> to <u>4 June</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4 June</u> , 19 <u>59</u> , and that death occurred at <u>5 p. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Walkersville, Md.</u> DATE SIGNED <u>5 June 1959</u>							
ACTUAL SIGNATURE <u>James F. Stoner Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>JAMES F. STONER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 7, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill Cemetery</u>	22d. LOCATION (City, town, or county) <u>W. Woodsboro</u>	(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton</u>			ADDRESS <u>Walkersville, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6766

## CERTIFICATE OF DEATH

06743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN IB <b>8 Weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>210 Seventh Avenue</b>		e. STREET ADDRESS <b>210 Seventh Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>MASON</b> Last <b>HARWOOD</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 Jan 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Newkirk</b>		14. MOTHER'S MAIDEN NAME <b>Mary Anderson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>George T. Harwood (Same as item #1)</b>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>June 13</b> , 19 <b>59</b> , to <b>June 19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 19</b> , 19 <b>59</b> , and that death occurred at <b>8:40P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. T. Byron Kao, M. D.</b>		ADDRESS (Street, city or town, state) <b>15 S. Maryland Ave</b>	
PHYSICIAN'S NAME (Type) <b>C. T. Byron Kao, M. D.</b>		DATE SIGNED <b>June 20, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 23, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

100713

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

6700

Reg. No. 100

Registration

Expiry

Duration

Place of death

Residence

Occupation

Age

110 - Avenue Ave

110 - Avenue Ave

Sex

Age

Sex

Age

Sex

11 - Ave

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6774

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Braddock Heights</u>				c. LENGTH OF STAY IN 1b <u>12 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Vindobona Inc</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>L</u> Last <u>Hoffman</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 Oct 1873</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>29</u> Days <u>29</u> Hours <u>19</u> Min. <u>59</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Cleaning</u>	
11. BIRTHPLACE (State or foreign country) <u>Unk</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Unk</u>				14. MOTHER'S MAIDEN NAME <u>Unk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT <u>Vindobona, Inc., (Same as item #1)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>151X</u> DUE TO (c) <u>151X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 year plus</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelonephritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/22</u> 19 <u>59</u> , to <u>6/29</u> 19 <u>59</u> , that I last saw the deceased alive on <u>6/28</u> 19 <u>59</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. R. Schoolman</u>				DATE SIGNED <u>2284 Market St Frederick 6/29/59</u>			
PHYSICIAN'S NAME (Type) <u>L. R. Schoolman, M. D.</u>				Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6-30-59</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6747

## CERTIFICATE OF DEATH

06745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 Brunswick</b>	
4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1959</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>E.</b> Last <b>Holland</b>		4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col.</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>4-15-1894</b>	
9. AGE (In years last birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months <b>05</b> Days <b>05</b> Hours <b>05</b> Min. <b>05</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Un known</b>		14. MOTHER'S MAIDEN NAME <b>Un known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Donald Holland, Knoxville, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO (b) <b>Hypertensive Cardiovascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4-5 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/9</b> , 19 <b>59</b> , to <b>6/11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/10</b> , 19 <b>59</b> , and that death occurred at <b>9 A</b> . M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St</b> DATE SIGNED <b>6/11/59</b> ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D. <b>Henry V. Chase</b> PHYSICIAN'S NAME (Type) <b>Frederick Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-15-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Petersville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. G. Fouts</b> ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fouts</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6748

## CERTIFICATE OF DEATH

06746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK CITY</u>		c. LENGTH OF STAY IN 1b <u>EIGHT DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X - RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>				1 d. STREET ADDRESS <u>MIDDLETOWN MD. R.1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALVERDA JANE HOLMES</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 21 - 19 59</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 14, 1876</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days <u>10 7</u>	IF UNDER 24 HRS. Hours Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SHARDSBURG WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>JOHN SNYDER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. ETHEL PAYNE MIDDLETOWN MD. R.1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>and Carcinoma of nasal septum</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 mos</u> <u>unknown</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 2, 1959</u> , to <u>June 21, 1959</u> , that I last saw the deceased alive on <u>June 20, 1959</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Kenneth C. Henson M.D. Middletown, Md. 6/23/59</u>							
ACTUAL SIGNATURE <u>Kenneth C. Henson</u>				PHYSICIAN'S NAME (Type) <u>Kenneth C. Henson Middletown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 24 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SAMPLES MANOR CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SAMPLES MANOR WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Ball</u>				ADDRESS <u>BOONSBORO MD</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 24 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Henshaw</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

2777

File No. 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		65		1880		BALTIMORE		MD		USA			
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED							
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY							
JAN 15 1945		BALTIMORE		MD		USA									
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION							
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST							
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION		CITY		STATE		COUNTRY			
J. H. HARRIS		J. H. HARRIS		JAN 15 1945		BALTIMORE		MD		USA					

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6749

## CERTIFICATE OF DEATH

Reg. Dist. No.

05603

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>" Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>FREDERICK MEMORIAL HOSP</u>		d. STREET ADDRESS <u>402 THOMAS AVE</u>	
3. NAME OF DECEASED (Type or print) <u>MICHAEL ALAN HUSSON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/30/59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>MARYLAND</u>	
13. FATHER'S NAME <u>JOHN ROLLAND HUSSON</u>		14. MOTHER'S MAIDEN NAME <u>SKIRLEY EDNA MAY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mother</u>		Address <u>402 Thomas Ave</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>768.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute viridic - myocarditis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/30</u> , 19 <u>59</u> , to <u>6/2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/2</u> , 19 <u>59</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frederick J. Herdich</u> M.D.		ADDRESS (Street, city or town, state) <u>250 GREEN PEEKWAY ST</u> DATE SIGNED <u>6/2/59</u>	
PHYSICIAN'S NAME (Type) <u>FREDERICK J. HERDICH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 3, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>June 4 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>William D. Rouse</u>			

2069242xv2

21080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6775

## CERTIFICATE OF DEATH

Reg. Dist. No.

06747

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckystown</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckeystown - RURAL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Home - RURAL - Rt. 4</b>		d. STREET ADDRESS <b>Buckeystown - Rt. 4</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sophia Whalen Lawson Jackson</b>		4. DATE OF DEATH Month Day Year <b>6 24 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/12/90</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework (domestic)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Point of Rocks, Md</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>William Whalen</b>		14. MOTHER'S MAIDEN NAME <b>Ida Bowins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-078-239</b>	
17. INFORMANT <b>Oscar Baltimore Jackson</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>Coronary heart failure, acute</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/17, 19 59</b> to <b>6/24, 19 59</b> that I last saw the deceased alive on <b>6/22, 19 59</b> , and that death occurred at <b>11:30 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>James B. Thomas, M.D.</b>		DATE SIGNED <b>Arthur S. Thomas</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-28-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Point of Rocks</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick-Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks # Fred. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6776

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film 6244 7-2-59 et

Reg. Dist. No. 06748

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Windsor R.F.D.</b>	
c. LENGTH OF STAY IN 1b <b>hours</b>		d. STREET ADDRESS <b>ALLEY ON STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ALLEY ON STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>Kloman</b> Middle <b>Klenwood</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 15 1940</b>
9. AGE (In years last birthday) <b>19</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>2</b> Hours <b>26</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BY MONTH</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Jones</b>		14. MOTHER'S MAIDEN NAME <b>Rosie Willis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-38-7721</b>	
17. INFORMANT <b>William Jones, New Windsor R.F.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot in left chest</b> 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Bullet passed thru left lung</b> (a), stating the underlying cause last. DUE TO <b>Heart + lacerated rt lung</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot in left chest</b>	
20c. TIME OF INJURY Month, Day, Year <b>Hour 12-03 June 27, 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Alley on St</b>		20f. (City or town) (County) (State) <b>Frederick Frederick, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 29, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/30/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT JOY</b>		22d. LOCATION (City, town, or county) (State) <b>UNIONTOWN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D.D. Hartley &amp; Sons Union Bridge Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNSTABLE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00318

DECEASED: **Frederick** **Frederick** **Frederick**

AGE: **40** **40** **40**

RESIDENCE: **Albany** **Albany** **Albany**

CAUSE OF DEATH: **Unlabeled** **Unlabeled** **Unlabeled**

**William Jones**

**Case No. 111**

**Unlabeled**

**Unlabeled**

**Unlabeled**

**Unlabeled**

**Unlabeled**

**Unlabeled**

**Unlabeled**

**Unlabeled**

**Unlabeled**

**Unlabeled**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06749

6750

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>8 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLORA</b> Middle <b>MAE</b> Last <b>KELLER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 Oct 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Olin W. Rice</b>	
14. MOTHER'S MAIDEN NAME <b>Emma E. Rice</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Belva K. Ayers (Same as item #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> <b>203X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/11/59</b> , 19 <b>59</b> , to <b>6/19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/19</b> , 19 <b>59</b> , and that death occurred at <b>12:45 P.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St. Frederick, Md.</b> DATE SIGNED <b>20 June 1959</b>			
ACTUAL SIGNATURE <b>Henry V. Chase</b>		M.D. <b>Henry V. Chase, M. D.</b>	
PHYSICIAN'S NAME (Type) <b>Henry V. Chase, M. D.</b>		<b>Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-22-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Jefferson, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Orlby &amp; Kiana</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06750

6767

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>311 Brunswick Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Grove</b> Last <b>Kidwell</b>		4. DATE OF DEATH Month <b>6</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>10</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired (Forman)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B.&amp;O. Shops</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wilfred Kidwell</b>		14. MOTHER'S MAIDEN NAME <b>Martha Sigafoose</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Ida Kidwell, Brunswick, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 14, 1958</b> to <b>6/10, 1959</b> , that I last saw the deceased alive on <b>6/10, 1959</b> , and that death occurred at <b>6:28 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brunswick, Md</b> DATE SIGNED <b>4/4/59</b>			
ACTUAL SIGNATURE <b>J.G.F. Smith</b>		M.D. <b>J.G.F. Smith</b>	
PHYSICIAN'S NAME (Type) <b>J.G.F. Smith</b>		<b>Brunswick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-13-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. L. G. G. G.</b>		ADDRESS <b>Brunswick, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	



## CERTIFICATE OF DEATH

1987

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. OCCUPATION [REDACTED]		8. MARITAL STATUS [REDACTED]		9. EDUCATION [REDACTED]	
10. BIRTH DATE [REDACTED]		11. BIRTH PLACE [REDACTED]		12. BIRTH COUNTRY [REDACTED]	
13. PREVIOUS MARRIAGES [REDACTED]		14. PREVIOUS DEATHS [REDACTED]		15. PREVIOUS DISEASES [REDACTED]	
16. PREVIOUS SURGERIES [REDACTED]		17. PREVIOUS TRAUMAS [REDACTED]		18. PREVIOUS DRUGS [REDACTED]	
19. PREVIOUS ALCOHOL [REDACTED]		20. PREVIOUS TOBACCO [REDACTED]		21. PREVIOUS OTHER [REDACTED]	
22. PREVIOUS OTHER [REDACTED]		23. PREVIOUS OTHER [REDACTED]		24. PREVIOUS OTHER [REDACTED]	
25. PREVIOUS OTHER [REDACTED]		26. PREVIOUS OTHER [REDACTED]		27. PREVIOUS OTHER [REDACTED]	
28. PREVIOUS OTHER [REDACTED]		29. PREVIOUS OTHER [REDACTED]		30. PREVIOUS OTHER [REDACTED]	
31. PREVIOUS OTHER [REDACTED]		32. PREVIOUS OTHER [REDACTED]		33. PREVIOUS OTHER [REDACTED]	
34. PREVIOUS OTHER [REDACTED]		35. PREVIOUS OTHER [REDACTED]		36. PREVIOUS OTHER [REDACTED]	
37. PREVIOUS OTHER [REDACTED]		38. PREVIOUS OTHER [REDACTED]		39. PREVIOUS OTHER [REDACTED]	
40. PREVIOUS OTHER [REDACTED]		41. PREVIOUS OTHER [REDACTED]		42. PREVIOUS OTHER [REDACTED]	
43. PREVIOUS OTHER [REDACTED]		44. PREVIOUS OTHER [REDACTED]		45. PREVIOUS OTHER [REDACTED]	
46. PREVIOUS OTHER [REDACTED]		47. PREVIOUS OTHER [REDACTED]		48. PREVIOUS OTHER [REDACTED]	
49. PREVIOUS OTHER [REDACTED]		50. PREVIOUS OTHER [REDACTED]		51. PREVIOUS OTHER [REDACTED]	
52. PREVIOUS OTHER [REDACTED]		53. PREVIOUS OTHER [REDACTED]		54. PREVIOUS OTHER [REDACTED]	
55. PREVIOUS OTHER [REDACTED]		56. PREVIOUS OTHER [REDACTED]		57. PREVIOUS OTHER [REDACTED]	
58. PREVIOUS OTHER [REDACTED]		59. PREVIOUS OTHER [REDACTED]		60. PREVIOUS OTHER [REDACTED]	
61. PREVIOUS OTHER [REDACTED]		62. PREVIOUS OTHER [REDACTED]		63. PREVIOUS OTHER [REDACTED]	
64. PREVIOUS OTHER [REDACTED]		65. PREVIOUS OTHER [REDACTED]		66. PREVIOUS OTHER [REDACTED]	
67. PREVIOUS OTHER [REDACTED]		68. PREVIOUS OTHER [REDACTED]		69. PREVIOUS OTHER [REDACTED]	
70. PREVIOUS OTHER [REDACTED]		71. PREVIOUS OTHER [REDACTED]		72. PREVIOUS OTHER [REDACTED]	
73. PREVIOUS OTHER [REDACTED]		74. PREVIOUS OTHER [REDACTED]		75. PREVIOUS OTHER [REDACTED]	
76. PREVIOUS OTHER [REDACTED]		77. PREVIOUS OTHER [REDACTED]		78. PREVIOUS OTHER [REDACTED]	
79. PREVIOUS OTHER [REDACTED]		80. PREVIOUS OTHER [REDACTED]		81. PREVIOUS OTHER [REDACTED]	
82. PREVIOUS OTHER [REDACTED]		83. PREVIOUS OTHER [REDACTED]		84. PREVIOUS OTHER [REDACTED]	
85. PREVIOUS OTHER [REDACTED]		86. PREVIOUS OTHER [REDACTED]		87. PREVIOUS OTHER [REDACTED]	
88. PREVIOUS OTHER [REDACTED]		89. PREVIOUS OTHER [REDACTED]		90. PREVIOUS OTHER [REDACTED]	
91. PREVIOUS OTHER [REDACTED]		92. PREVIOUS OTHER [REDACTED]		93. PREVIOUS OTHER [REDACTED]	
94. PREVIOUS OTHER [REDACTED]		95. PREVIOUS OTHER [REDACTED]		96. PREVIOUS OTHER [REDACTED]	
97. PREVIOUS OTHER [REDACTED]		98. PREVIOUS OTHER [REDACTED]		99. PREVIOUS OTHER [REDACTED]	
100. PREVIOUS OTHER [REDACTED]		101. PREVIOUS OTHER [REDACTED]		102. PREVIOUS OTHER [REDACTED]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6751

## CERTIFICATE OF DEATH

06751

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> b. STATE <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Fredrick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FRED</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Levittown</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fred Mem.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>H</b> Last <b>King</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-26-37</b>
9. AGE (In years lost birthday) yrs. <b>#</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>22</b>	
IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>IND.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Woodrow W. King</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Hoet</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Irreversible shock</b> <b>571.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Dehydration</b> DUE TO (c) <b>Gastro enteritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>26 June, 1959</b> , to <b>28 June 1959</b> , that I last saw the deceased alive on <b>28 June 1959</b> , and that death occurred at <b>11 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. MELDRICK</b>		ADDRESS (Street, city or town, state) <b>N. Market St. Fredrick MD</b>	
DATE SIGNED <b>6-30-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. George Thurmont</b>		ADDRESS <b>12069455X</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
JAMES EARL RAY		M		35		12-1-41		MOBILE, ALABAMA		CLOCK REPAIR		SINGLE		HEART DISEASE		MOBILE, ALABAMA		12-1-68		J. EARL RAY		J. EARL RAY	
13. PLACE OF INTERMENT		14. NAME OF CEMETERY		15. DATE OF INTERMENT		16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGYMAN		18. SIGNATURE OF CHURCH		19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF REGISTRAR		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF REGISTRAR		24. SIGNATURE OF WITNESSES	
MOBILE, ALABAMA		MOBILE, ALABAMA		12-1-68		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY	

92-50000-11  
J. EARL RAY  
J. EARL RAY

6768

CERTIFICATE OF DEATH

06752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>20 East "C"</b>				d. STREET ADDRESS <b>20 East "C"</b>			
3. NAME OF DECEASED (Type or print) First <b>Lola</b> Middle <b>Amelia</b> Last <b>Kline</b>				4. DATE OF DEATH Month <b>6</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-29 1891</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>29</b> Hours <b>19</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George O. Barger</b>				14. MOTHER'S MAIDEN NAME <b>Altie A. Mc Bride</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>W.M. Kline</b> Address <b>Brunswick, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage - Rt.</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes mellitus</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>yes.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>6-25-1959</b> to <b>6-29-1959</b> , that I last saw the deceased alive on <b>6-29-1959</b> , and that death occurred at <b>12 Noon</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C.E. Pruitt</b>				ADDRESS (Street, city or town, state) <b>Brunswick, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>C.E. Pruitt</b>				DATE SIGNED <b>6-29-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-2-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. W. Fouts</b>				ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Fouts</b>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.)

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6777

## CERTIFICATE OF DEATH

06753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MIDDLETOWN</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>090 Valley View Nursing Home</u>				d. STREET ADDRESS <u>Route 7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Allice</u> Middle <u>VIRGINIA</u> Last <u>Klipp</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-23-1891</u>	
9. AGE (In years last birthday) <u>68 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Leather Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Klipp</u>			
14. MOTHER'S MAIDEN NAME <u>Ida F. Hart</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>215-20-9143</u>				17. INFORMANT <u>Miss Margaret S. Klipp m.d.</u> Address <u>Rt. 7-Frederick Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis (Generalized)</u> DUE TO (c) <u>Hypertrophia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Middleton Md</u>				20g. (County) <u>Frederick</u>		20h. (State) <u>Md</u>	
21. I certify that I attended the deceased from <u>June 20, 1959</u> , to <u>June 29, 1959</u> , that I last saw the deceased alive on <u>June 29, 1959</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Elmer Harp</u>				ADDRESS (Street, city or town, state) <u>Middleton Md</u>			
PHYSICIAN'S NAME (Type) <u>J. Elmer Harp</u>				DATE SIGNED <u>6-29-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-2-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Springs Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>W. of Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Dailey, Jr.</u>				ADDRESS <u>Frederick Md.</u>		24a. REC'D BY REGISTRAR <u>UL 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Huns</u>							



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6778 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06754

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick RD Route 15</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Gen. Hosp.</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <span style="float: right;">03X-2</span> d. STREET ADDRESS <u>1136 Englewood Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Tamara Lillian Krauss</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>June 28 1959</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
<b>8. DATE OF BIRTH</b> <u>Oct. 5, 1896</u>		<b>9. AGE</b> (In years last birthday) <u>62</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>House wife</u>					
<b>11. BIRTHPLACE</b> (State or foreign country) <u>VIRGINIA</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>					
<b>13. FATHER'S NAME</b> <u>SMITH MARTIN</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Sallie Johnson</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>					
<b>17. INFORMANT</b> Address <u>MR. Frederick W. Krauss</u>			<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Base of Skull</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushed chest</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>		
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.</b>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Making it turn on Route 15, struck by tractor-trailer</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>11:40 a. m. 6/28 1959</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Route 15</u>			
<b>20f. (City or town)</b> <u>Frederick</u>			<b>20g. (County)</b> <u>Frederick</u>		<b>20h. (State)</b> <u>Md</u>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
<b>ACTUAL SIGNATURE</b> <u>B. O. Thomas</u>			<b>DATE SIGNED</b> <u>June 28, 1959</u>					
<b>EXAMINER'S NAME (Type)</b> <u>B. O. Thomas, MD</u>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>July 2, 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Meadowridge Cem.</u>				
<b>22d. LOCATION</b> (City, town, or county) <u>Ba Lto. Md</u>		<b>22e. (State)</b>						
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>S. Truman Schuch</u>			<b>ADDRESS</b> <u>3512 Frederick Ave.</u>					
<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>JUL 1 '59</u>			<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

6779 Item 1 FilmG244 6-19-59 et  
CERTIFICATE OF DEATH

06755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Middletown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private home</b>				d. STREET ADDRESS <b>West Main Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lena E Lamar</b>				4. DATE OF DEATH Month Day Year <b>June 5 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 28, 1877</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
13. FATHER'S NAME <b>Henry Newcomer</b>				14. MOTHER'S MAIDEN NAME <b>Louisa J. Harp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. David Young</b> Address <b>Middletown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 17, 1959</b> , to <b>June 5, 1959</b> , that I last saw the deceased alive on <b>June 3, 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Middletown</b> DATE SIGNED <b>6-5-59</b>							
ACTUAL SIGNATURE <b>J Elmer Harp</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. J Elmer Harp</b>				<b>Middletown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 7, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reform cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>JUN 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harp</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. After the attending physician and completed, the certificate should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6752

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN TB <b>Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>42 East Fourth Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>RAYMOND</b> Last <b>LONG, SR.</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1896</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>20</b> Hours <b>19</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Elmer Long, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Haupt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-10-234</b>	
17. INFORMANT <b>Mrs. Violet V. Long, Frederick, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral hemorrhage secondary to</b> DUE TO <b>right side</b> (c) <b>right side</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b> <b>22 months</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Jan 19 50</b> to <b>June 20 19 57</b> , that I last saw the deceased alive on <b>June 20 19 57</b> , and that death occurred at <b>5:20 P</b> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D. <b>Professional Building</b>		ADDRESS (Street, city or town, state) <b>Frederick, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M.D.</b>		DATE SIGNED <b>6/22/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 24, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUN 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10750

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

6752

NAME OF DECEASED J. J. J. J.		AGE 67	
SEX Male		RACE White	
DATE OF DEATH 1918		PLACE OF DEATH Home	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
PLACE OF BIRTH Maryland		DATE OF BIRTH 1851	
OCCUPATION Farmer		EDUCATION High School	
MARITAL STATUS Married		SPOUSE'S NAME J. J. J. J.	
RESIDENCE 123 Main St, Baltimore, Md.		PREVIOUS RESIDENCE None	
DATE OF INTERVIEW 1918		INTERVIEWER J. J. J. J.	
SIGNATURE OF DECEASED J. J. J. J.		SIGNATURE OF WITNESS J. J. J. J.	
DATE OF SIGNATURE 1918		DATE OF SIGNATURE 1918	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, fill in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6780

## CERTIFICATE OF DEATH

06757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>109 Prospect Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Jane</u> Last <u>Lowman</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1863</u>
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Dorsey</u>		14. MOTHER'S MAIDEN NAME <u>Annie Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Margie Hoade - Mt. Airy, Md.</u>		Address <u>109 Prospect Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>25 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 29, 1959</u> , to <u>June 1, 1959</u> , that I last saw the deceased alive on <u>May 29, 1959</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.		ADDRESS (Street, city or town, state) <u>Mt. Airy, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		DATE SIGNED <u>6/1/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-4-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WINE GROVE</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Airy Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Wartz</u>		ADDRESS <u>Winfield, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH Jan 15 1885		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. CAUSE OF DEATH Heart Failure		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. SIGNATURE OF PHYSICIAN J. H. Harris	
11. SIGNATURE OF REGISTRAR J. H. Harris		12. SIGNATURE OF WITNESS J. H. Harris		13. SIGNATURE OF WITNESS J. H. Harris		14. SIGNATURE OF WITNESS J. H. Harris		15. SIGNATURE OF WITNESS J. H. Harris	
16. SIGNATURE OF WITNESS J. H. Harris		17. SIGNATURE OF WITNESS J. H. Harris		18. SIGNATURE OF WITNESS J. H. Harris		19. SIGNATURE OF WITNESS J. H. Harris		20. SIGNATURE OF WITNESS J. H. Harris	
21. SIGNATURE OF WITNESS J. H. Harris		22. SIGNATURE OF WITNESS J. H. Harris		23. SIGNATURE OF WITNESS J. H. Harris		24. SIGNATURE OF WITNESS J. H. Harris		25. SIGNATURE OF WITNESS J. H. Harris	
26. SIGNATURE OF WITNESS J. H. Harris		27. SIGNATURE OF WITNESS J. H. Harris		28. SIGNATURE OF WITNESS J. H. Harris		29. SIGNATURE OF WITNESS J. H. Harris		30. SIGNATURE OF WITNESS J. H. Harris	
31. SIGNATURE OF WITNESS J. H. Harris		32. SIGNATURE OF WITNESS J. H. Harris		33. SIGNATURE OF WITNESS J. H. Harris		34. SIGNATURE OF WITNESS J. H. Harris		35. SIGNATURE OF WITNESS J. H. Harris	
36. SIGNATURE OF WITNESS J. H. Harris		37. SIGNATURE OF WITNESS J. H. Harris		38. SIGNATURE OF WITNESS J. H. Harris		39. SIGNATURE OF WITNESS J. H. Harris		40. SIGNATURE OF WITNESS J. H. Harris	
41. SIGNATURE OF WITNESS J. H. Harris		42. SIGNATURE OF WITNESS J. H. Harris		43. SIGNATURE OF WITNESS J. H. Harris		44. SIGNATURE OF WITNESS J. H. Harris		45. SIGNATURE OF WITNESS J. H. Harris	
46. SIGNATURE OF WITNESS J. H. Harris		47. SIGNATURE OF WITNESS J. H. Harris		48. SIGNATURE OF WITNESS J. H. Harris		49. SIGNATURE OF WITNESS J. H. Harris		50. SIGNATURE OF WITNESS J. H. Harris	
51. SIGNATURE OF WITNESS J. H. Harris		52. SIGNATURE OF WITNESS J. H. Harris		53. SIGNATURE OF WITNESS J. H. Harris		54. SIGNATURE OF WITNESS J. H. Harris		55. SIGNATURE OF WITNESS J. H. Harris	
56. SIGNATURE OF WITNESS J. H. Harris		57. SIGNATURE OF WITNESS J. H. Harris		58. SIGNATURE OF WITNESS J. H. Harris		59. SIGNATURE OF WITNESS J. H. Harris		60. SIGNATURE OF WITNESS J. H. Harris	
61. SIGNATURE OF WITNESS J. H. Harris		62. SIGNATURE OF WITNESS J. H. Harris		63. SIGNATURE OF WITNESS J. H. Harris		64. SIGNATURE OF WITNESS J. H. Harris		65. SIGNATURE OF WITNESS J. H. Harris	
66. SIGNATURE OF WITNESS J. H. Harris		67. SIGNATURE OF WITNESS J. H. Harris		68. SIGNATURE OF WITNESS J. H. Harris		69. SIGNATURE OF WITNESS J. H. Harris		70. SIGNATURE OF WITNESS J. H. Harris	
71. SIGNATURE OF WITNESS J. H. Harris		72. SIGNATURE OF WITNESS J. H. Harris		73. SIGNATURE OF WITNESS J. H. Harris		74. SIGNATURE OF WITNESS J. H. Harris		75. SIGNATURE OF WITNESS J. H. Harris	
76. SIGNATURE OF WITNESS J. H. Harris		77. SIGNATURE OF WITNESS J. H. Harris		78. SIGNATURE OF WITNESS J. H. Harris		79. SIGNATURE OF WITNESS J. H. Harris		80. SIGNATURE OF WITNESS J. H. Harris	
81. SIGNATURE OF WITNESS J. H. Harris		82. SIGNATURE OF WITNESS J. H. Harris		83. SIGNATURE OF WITNESS J. H. Harris		84. SIGNATURE OF WITNESS J. H. Harris		85. SIGNATURE OF WITNESS J. H. Harris	
86. SIGNATURE OF WITNESS J. H. Harris		87. SIGNATURE OF WITNESS J. H. Harris		88. SIGNATURE OF WITNESS J. H. Harris		89. SIGNATURE OF WITNESS J. H. Harris		90. SIGNATURE OF WITNESS J. H. Harris	
91. SIGNATURE OF WITNESS J. H. Harris		92. SIGNATURE OF WITNESS J. H. Harris		93. SIGNATURE OF WITNESS J. H. Harris		94. SIGNATURE OF WITNESS J. H. Harris		95. SIGNATURE OF WITNESS J. H. Harris	
96. SIGNATURE OF WITNESS J. H. Harris		97. SIGNATURE OF WITNESS J. H. Harris		98. SIGNATURE OF WITNESS J. H. Harris		99. SIGNATURE OF WITNESS J. H. Harris		100. SIGNATURE OF WITNESS J. H. Harris	

1



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6753

## CERTIFICATE OF DEATH

06758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>7 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>113 E. 5th street</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// Frederick</b> d. STREET ADDRESS <b>113 E. 5th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Vannie Agnes Luby</b>		4. DATE OF DEATH Month Day Year <b>6 30 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/ 1/80</b>
9. AGE (In years last birthday) <b>79 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Calvin T. Luby</b>	
14. MOTHER'S MAIDEN NAME <b>Hertes Brown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>217-07-0737</b>		INFORMANT <b>Pauline Hammond</b> Address <b>113 E. 5th Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Acute myocardial failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Now year</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/2, 1959</b> , to <b>6/30, 1959</b> , that I lost saw the deceased alive on <b>6/29, 1959</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>228 N. Market Street Frederick, Md</b> DATE SIGNED <b>7/3/59</b> ACTUAL SIGNATURE <b>James B. Thomas</b> M.D. PHYSICIAN'S NAME (Type) <b>Frederick, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles B. Hick III</b> ADDRESS <b>24 W. All Saint St</b>		24a. REC'D BY REGISTRAR <b>JUL 9 59</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Carling A. Hines</b>	

80500

CERTIFICATE OF DEATH

80500

1. Name of deceased: *John A. Smith*  
2. Sex: *Male*  
3. Age: *65*  
4. Date of death: *Jan 15 1960*  
5. Place of death: *Home*  
6. Cause of death: *Heart disease*  
7. Signature of physician: *Dr. J. H. Jones*  
8. Signature of registrar: *W. H. Brown*  
9. Date of registration: *Jan 16 1960*  
10. Place of registration: *City of New York*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6754 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// Frederick</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>425 South Market</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Douglas</b> Middle <b>Wayne</b> Last <b>Moss</b>				4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1958</b>		9. AGE (In years last birthday) yrs. <b>10</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Frederick County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Elmer L Moss</b>				14. MOTHER'S MAIDEN NAME <b>Anna Lee Delaughter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Frederick, Md.</b> <b>Anna Lee Moss, 4 25 S. Market St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Virial Pneumonitis</b> <b>492x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B.O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 30, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>7-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Locust Valley Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick County Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2069314x47

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		Jan 15, 1925	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
New York City		123 Main St, Baltimore		Heart Disease		Natural	
Occupation		Education		Previous Illnesses		Drugs Taken	
Teacher		High School		Hypertension		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED  
JAN 16 1925  
BALTIMORE

FILED  
JAN 16 1925  
BALTIMORE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6781 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										06761	
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville, R.F.D. 2				c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Myersville R.F.D. 2				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)										d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Austian Paul Myers			4. DATE OF DEATH Month Day Year June 19 19 59								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 10, 1916 43 yrs.		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY own gen. farm		11. BIRTHPLACE (State or foreign country) Frederick Co.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles S. Myers					14. MOTHER'S MAIDEN NAME Amanda C. Moser						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-30-9175		17. INFORMANT Mrs. Austin P. Myers, Myersville, R.D. 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.0 DUE TO Acute Alcoholism Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause lost. (b) <del>Alcoholism</del> (c) <del>Alcoholism</del>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in small dairy spring, head submerged under water, no other part of body in water. Alcohol from spinal fluid							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. - - - 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm (Home)		20f. (City or town) near Myersville		20g. (County) Fred		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE B.O. Thomas, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) B.O. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				June 19, 1959							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1959		22c. NAME OF CEMETERY OR CREMATORY Pleasant Walk U. B. Nr Myersville, Fred. Co. Md.				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle				ADDRESS Myersville, Md.				24a. REC'D BY REGISTRAR JUN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	





OFFICE OF THE COMMISSIONER

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Residence		Place of Death	
Marysville, D.D.		Marysville, D.D.		Marysville, D.D.	
Age		Sex		Race	
30		Male		White	
Date of Death		Cause of Death		Manner of Death	
10.1918		Heart Disease		Natural	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner	
J. J. Thomas		J. J. Thomas		J. J. Thomas	
Date of Certificate		Date of Expiration		Date of Renewal	
10.1.18		10.1.18		10.1.18	

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Medical Examiner's Office along with form PM3. Page 5 should be retained by the Medical Director. Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

6755

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06762

Items 20 b to f Film G-244 7/6/59 rs

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt Airy R.F.D.4</b>	
c. LENGTH OF STAY IN <b>Life</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edward Ray Naill</b>		4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1959</b>
9. AGE (In years last birthday) yrs. <b>4</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b> Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bernard R. Naill</b>		14. MOTHER'S MAIDEN NAME <b>Janet L. Naill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Janet L. Naill, Mt Airy R.F.D.4</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation &amp; asperation</b> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>asphyxia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No injury</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>8</b> p. m. <b>6/21 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Fred. Mem. Hosp.</b>		20f. (City or town) (County) (State) <b>Frederick, Frederick Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 22, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Locust Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.M. Wertz</b>		ADDRESS <b>Winfield, Md</b>	
24a. REC'D BY REGISTRAR <b>JUN 24 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Religion		Marital Status		Place of Birth		Date of Birth	
James J. Hall		Male		45		White		Catholic		Married		Maryland		June 15, 1929	
Residence		Occupation		Cause of Death		Manner of Death		Time of Death		Place of Death		Date of Death		Signature of Examiner	
1000 N. ...		...		...		...		...		...		...		...	
Medical History		Present Illness		Post-mortem Examination		Toxicology		Microscopic Examination		Bacteriology		X-ray Examination		Other	
...		...		...		...		...		...		...		...	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Jury		Signature of Witnesses		Signature of ...		Signature of ...		Signature of ...	
Date		Time		Place		City		County		State		Country		...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06763

6756

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	c. LENGTH OF STAY IN 1b <b>8 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Rural Middletown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>1</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Franklin</b> G. Middle <b>G.</b> Last <b>Norris</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/4/1911</b>
9. AGE (In years lost birthday) <b>47 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>grocery store</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Franklin G. Norris</b>		14. MOTHER'S MAIDEN NAME <b>Minnie E. Powers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-10-9219</b>	
17. INFORMANT <b>Mrs. Mary Norris, Middletown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> <b>330x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital aneurysm of the</b> DUE TO (c) <b>circle of Willis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lifetime</b>			INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/19</b> , 19 <b>59</b> , to <b>6/27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/27</b> , 19 <b>59</b> , and that death occurred at <b>4:45 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D. <b>4 E. Church St</b> <b>6/27/59</b> PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b> <b>Frederick Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE WHEREOF <b>6/30/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Locust Valley Ch. of God Cem., Fredk. Co., Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 30 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 2/57

FOR STATE  
HEALTH DEPT.



Items 20b to 20f of MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Film G-244 rs  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Item 7 film G244 b-50-59 et

06764

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>6782</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg R.F.D.</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>			d. STREET ADDRESS <b>RD#2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>George</b>			4. DATE OF DEATH <b>June 19 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>Oct. 4, 1881</b>		9. AGE (In years last birthday) <b>77</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Peddicord</b>			14. MOTHER'S MAIDEN NAME <b>Ellen Butts</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Peddicord 3711 Belvedere Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Tracho-Bronchitis</b> <b>916.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>due to inhaling smoke and flame</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pouring kerosene on live coals, blazed into face</b>			
20c. TIME OF INJURY Month, Day, Year <b>6/17 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Emmitsburg, RFD; Fred.</b>		20g. (County) <b>Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>June 19, 1959</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 22, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Anthony's</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson</b>		ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		24c. LOCATION (City, town, or county) <b>R.D. 2</b>			
24d. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>					

C. E. Wilson

FOR STATE  
HOSPITAL

6782

Frederick

George P. D.

Life

Proctor Medical Hospital

George

Podicox

White

Mythia

John White

John White

John

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due to smoking and illness

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6783

## CERTIFICATE OF DEATH

06765

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. #2 Middletown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley View Nursing Home</b>				d. STREET ADDRESS <b>Rt. #2 Middletown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George William Poole, Sr.</b>				4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> <del>Never married</del> <del>Widowed</del> <del>Divorced</del>		8. DATE OF BIRTH <b>5/8/1892</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Ernest F. Poole</b>				14. MOTHER'S MAIDEN NAME <b>Annie R. Topper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. George W. Poole, Sr. Rt. #2 Middletown, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 wks</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>58</b> , to <b>June 6</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 23</b> , 19 <b>59</b> , and that death occurred at <b>12:28 P.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Kenneth C. Hanson</b> M.D.				ADDRESS (Street, city or town, state) <b>Middletown, Md.</b> DATE SIGNED <b>6/8/59</b>			
PHYSICIAN'S NAME (Type or print) <b>Dr. Kenneth C. Hanson</b>				M.D. <b>Middletown, Maryland</b> <b>6/8/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Bailey</b>				ADDRESS <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 12 59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Branch</b>	

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Great F. Pools

Mr. George H. Poole, Jr., 17.

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*The Journal of Law, Economics, & Organization*, V16 N1

1992

1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06766

6757

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>30 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>543 North Market Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>ZIMMERMAN</b> Last <b>RENN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 Oct 1901</b>	
9. AGE (In years last birthday) yrs. <b>57</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Adamstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant Business</b>			
13. FATHER'S NAME <b>William H. Renn</b>				14. MOTHER'S MAIDEN NAME <b>Edith G. Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-32-4365</b>		17. INFORMANT <b>Mrs. Mildred F. Renn (Same as item #1)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>30-45 min</b> <b>4-5 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>FEB 19</b> , 19 <b>59</b> , to <b>June 29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 28</b> , 19 <b>59</b> , and that death occurred at <b>6:45A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St.</b> DATE SIGNED <b>29 June 1959</b> ACTUAL SIGNATURE <b>Henry V. Chase M.D.</b> PHYSICIAN'S NAME (Type) <b>Henry V. Chase, M. D.</b> <b>Frederick, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-2-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



— 1 —

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6758

## CERTIFICATE OF DEATH

06767

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN TB <b>1-Day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. STREET ADDRESS <b>Shookstown</b>	
3. NAME OF DECEASED (Type or print) First <b>ISABELL</b> Middle <b>RAY</b> Last <b>SCHULTZ</b>		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 15, 1899</b>
9. AGE (In years last birthday) yrs. <b>59</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Hildebrand</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Main</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-1979E</b>	
17. INFORMANT <b>Mr. Albert W. Schultz, R.F.D.#7, Frederick, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April, 1953</b> to <b>6-7-1959</b> , that I last saw the deceased alive on <b>6-7-59</b> , and that death occurred at <b>4:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Rex R. Martin</b>		ADDRESS (Street, city or town, state) <b>East Church Street</b> DATE SIGNED <b>6/8/59</b>	
PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M.D.</b>		<b>Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 10, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rocky Springs Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JUN 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6759

## CERTIFICATE OF DEATH

06768

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Myersville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEM. HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELMER F. Franklin</b> First Middle Last		4. DATE OF DEATH <b>JUNE 5 1959</b> Month Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1899</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Gen. Mdse.</b>	11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John O. Shepley</b>	
14. MOTHER'S MAIDEN NAME <b>Laura C. Brandenburg</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give year or dates of service) <b>W.W. # 1</b>	
16. SOCIAL SECURITY NO. <b>219-20-0770</b>		17. INFORMANT <b>Mrs. Miriam P. Shepley, Myersville, Md</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis following 410X</b> DUE TO <b>embolization</b> (b) <b>Rheumatic Heart dis. with mitral</b> DUE TO <b>and aortic valve stenosis + an. fibrillation</b> (c) <b>and aortic valve stenosis + an. fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus (1 yr.); Bleeding peptic ulcer (2 mos)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 5, 1959</b> , to <b>June 5, 1959</b> , that I last saw the deceased alive on <b>June 5, 1959</b> , and that death occurred at <b>4:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles H. Conley, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>Proximinal Bldg. Frederick, Md.</b> DATE SIGNED <b>6/5/59</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES H. CONLEY, JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 8, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Lutheran</b>	22d. LOCATION (City, town, or county) (State) <b>Myersville, Fred. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b> ADDRESS <b>Myersville, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "New York"]		DATE OF BIRTH [Faint text, possibly "Jan 1, 1900"]		PLACE OF DEATH [Faint text, possibly "Baltimore"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "Dec 15, 1945"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]	
NAME OF PHYSICIAN [Faint text, possibly "Dr. J. Smith"]		NAME OF CLERGYPERSON [Faint text, possibly "Rev. W. Brown"]		NAME OF FUNERAL HOME [Faint text, possibly "St. Mary's"]	
NAME OF NEXT OF KIN [Faint text, possibly "Mrs. J. Doe"]		ADDRESS OF NEXT OF KIN [Faint text, possibly "123 Main St"]		CITY AND STATE [Faint text, possibly "Baltimore, MD"]	
NAME OF WITNESS [Faint text, possibly "John Doe"]		ADDRESS OF WITNESS [Faint text, possibly "456 Oak St"]		CITY AND STATE [Faint text, possibly "Baltimore, MD"]	
NAME OF REGISTRAR [Faint text, possibly "John Doe"]		ADDRESS OF REGISTRAR [Faint text, possibly "789 Pine St"]		CITY AND STATE [Faint text, possibly "Baltimore, MD"]	



6784

## CERTIFICATE OF DEATH

06769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, nr. Libertytown</i>				c. LENGTH OF STAY IN 1b <i>Life</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>-</i>				d. STREET ADDRESS <i>X Rural, Libertytown</i>			
3. NAME OF DECEASED (Type or print) First <i>ISAAC</i> Middle <i>SMITH</i> Last <i>SMITH</i>				4. DATE OF DEATH Month <i>June</i> Day <i>30</i> Year <i>1959</i>			
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 31, 1873</i>	9. AGE (In years last birthday) <i>86</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Miner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Copper mine</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Anthony Smith</i>				14. MOTHER'S MAIDEN NAME <i>Susan Crum</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT Address <i>Mr. Charles J. Smith, Fred., Rl., Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial infarction</i> DUE TO (c) <i>Arteriosclerotic cardiovascular disease</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Malignancy of right side of face &amp; eye.</i>							INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i> <i>3 weeks</i> <i>several years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <i>July</i> , 1957, to <i>July 30</i> , 1959, that I last saw the deceased alive on <i>June 19</i> , 1959, and that death occurred at <i>12:30 P. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>E. A. Dettbarn</i>				ADDRESS (Street, city or town, state) <i>Walkersville, Md.</i> DATE SIGNED <i>July 1/59</i>			
PHYSICIAN'S NAME (Type) <i>E. A. DETTBARN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>July 3, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Chapel Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>nr. Libertytown, Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Barton</i> ADDRESS <i>Walkersville, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JUL 6 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00380

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

## CERTIFICATE OF DEATH

Date of Birth

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. RACE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]	
6. DATE OF DEATH [Faint text]		7. PLACE OF DEATH [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]		10. SIGNATURE OF DECEASED [Faint text]	
11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF PHYSICIAN [Faint text]		13. SIGNATURE OF CLERK [Faint text]		14. SIGNATURE OF JURY [Faint text]		15. SIGNATURE OF JUDGE [Faint text]	
16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF WITNESS [Faint text]		18. SIGNATURE OF PHYSICIAN [Faint text]		19. SIGNATURE OF CLERK [Faint text]		20. SIGNATURE OF JURY [Faint text]	
21. SIGNATURE OF JUDGE [Faint text]		22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF WITNESS [Faint text]		24. SIGNATURE OF PHYSICIAN [Faint text]		25. SIGNATURE OF CLERK [Faint text]	
26. SIGNATURE OF JURY [Faint text]		27. SIGNATURE OF JUDGE [Faint text]		28. SIGNATURE OF DECEASED [Faint text]		29. SIGNATURE OF WITNESS [Faint text]		30. SIGNATURE OF PHYSICIAN [Faint text]	
31. SIGNATURE OF CLERK [Faint text]		32. SIGNATURE OF JURY [Faint text]		33. SIGNATURE OF JUDGE [Faint text]		34. SIGNATURE OF DECEASED [Faint text]		35. SIGNATURE OF WITNESS [Faint text]	
36. SIGNATURE OF PHYSICIAN [Faint text]		37. SIGNATURE OF CLERK [Faint text]		38. SIGNATURE OF JURY [Faint text]		39. SIGNATURE OF JUDGE [Faint text]		40. SIGNATURE OF DECEASED [Faint text]	
41. SIGNATURE OF WITNESS [Faint text]		42. SIGNATURE OF PHYSICIAN [Faint text]		43. SIGNATURE OF CLERK [Faint text]		44. SIGNATURE OF JURY [Faint text]		45. SIGNATURE OF JUDGE [Faint text]	
46. SIGNATURE OF DECEASED [Faint text]		47. SIGNATURE OF WITNESS [Faint text]		48. SIGNATURE OF PHYSICIAN [Faint text]		49. SIGNATURE OF CLERK [Faint text]		50. SIGNATURE OF JURY [Faint text]	
51. SIGNATURE OF JUDGE [Faint text]		52. SIGNATURE OF DECEASED [Faint text]		53. SIGNATURE OF WITNESS [Faint text]		54. SIGNATURE OF PHYSICIAN [Faint text]		55. SIGNATURE OF CLERK [Faint text]	
56. SIGNATURE OF JURY [Faint text]		57. SIGNATURE OF JUDGE [Faint text]		58. SIGNATURE OF DECEASED [Faint text]		59. SIGNATURE OF WITNESS [Faint text]		60. SIGNATURE OF PHYSICIAN [Faint text]	
61. SIGNATURE OF CLERK [Faint text]		62. SIGNATURE OF JURY [Faint text]		63. SIGNATURE OF JUDGE [Faint text]		64. SIGNATURE OF DECEASED [Faint text]		65. SIGNATURE OF WITNESS [Faint text]	
66. SIGNATURE OF PHYSICIAN [Faint text]		67. SIGNATURE OF CLERK [Faint text]		68. SIGNATURE OF JURY [Faint text]		69. SIGNATURE OF JUDGE [Faint text]		70. SIGNATURE OF DECEASED [Faint text]	
71. SIGNATURE OF WITNESS [Faint text]		72. SIGNATURE OF PHYSICIAN [Faint text]		73. SIGNATURE OF CLERK [Faint text]		74. SIGNATURE OF JURY [Faint text]		75. SIGNATURE OF JUDGE [Faint text]	
76. SIGNATURE OF DECEASED [Faint text]		77. SIGNATURE OF WITNESS [Faint text]		78. SIGNATURE OF PHYSICIAN [Faint text]		79. SIGNATURE OF CLERK [Faint text]		80. SIGNATURE OF JURY [Faint text]	
81. SIGNATURE OF JUDGE [Faint text]		82. SIGNATURE OF DECEASED [Faint text]		83. SIGNATURE OF WITNESS [Faint text]		84. SIGNATURE OF PHYSICIAN [Faint text]		85. SIGNATURE OF CLERK [Faint text]	
86. SIGNATURE OF JURY [Faint text]		87. SIGNATURE OF JUDGE [Faint text]		88. SIGNATURE OF DECEASED [Faint text]		89. SIGNATURE OF WITNESS [Faint text]		90. SIGNATURE OF PHYSICIAN [Faint text]	
91. SIGNATURE OF CLERK [Faint text]		92. SIGNATURE OF JURY [Faint text]		93. SIGNATURE OF JUDGE [Faint text]		94. SIGNATURE OF DECEASED [Faint text]		95. SIGNATURE OF WITNESS [Faint text]	
96. SIGNATURE OF PHYSICIAN [Faint text]		97. SIGNATURE OF CLERK [Faint text]		98. SIGNATURE OF JURY [Faint text]		99. SIGNATURE OF JUDGE [Faint text]		100. SIGNATURE OF DECEASED [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6785

## CERTIFICATE OF DEATH

06770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Petersville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Petersville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) First <b>Foster</b> Middle <b>Raymond</b> Last <b>Snoots</b>		4. DATE OF DEATH Month <b>6</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-26-1902</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Fruit Growers Ice Cars</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry C. Snoots</b>		14. MOTHER'S MAIDEN NAME <b>Alice Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT <b>Mrs. Marion Snoots, Knoxville, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> (c) <b>Obesity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>2 yrs.</b> <b>15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/12/59</b> , to <b>6/29/59</b> , that I last saw the deceased alive on <b>4/12/59</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. D. Brice</b> M.D.		ADDRESS (Street, city or town, state) <b>Jefferson</b> DATE SIGNED <b>6/30/59</b>	
PHYSICIAN'S NAME (Type) <b>A. T. BRICE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-2-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marks</b>		22d. LOCATION (City, town, or county) (State) <b>Petersville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Lutz</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 2 59</b>	
ADDRESS <b>Brunswick, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Hanks</b>	

5170

1000

100

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

6760

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JEFFERSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL</u>				1. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>INFANT</u> Middle <u>SOLLENBERGER</u> Last <u>SOLLENBERGER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 14, 1959</u>		9. AGE (In years lost birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u> Days _____ Hours _____	IF UNDER 24 HRS. Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PAUL V SOLLENBERGER</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE BARNES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>PAUL SOLLENBERGER</u> Address <u>Jefferson Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration pneumonia?</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>14 June, 1959</u> , to <u>16 June, 1959</u> , that I last saw the deceased alive on <u>16 June, 1959</u> , and that death occurred at <u>2 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>220 N. MARKET ST</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Fred J. Heldrich Jr.</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>FRED J. HELDRICH JR.</u> <u>FREDERICK, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Olaf</u>		22d. LOCATION (City, town, or county) <u>Fredrick Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blair G. Galt</u> ADDRESS <u>Fredrick Md</u>				24a. REC'D BY REGISTRAR <u>JUN 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069413XV3





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6761

CERTIFICATE OF DEATH

06772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN TB <b>over 45 years</b> 10 <b>Frederick, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>332 East 3rd Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Snively</b> Middle <b>Elsworth</b> Last <b>Spangler</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 21, 1891</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Molder at the Frederick Iron and Steel Co. Pennsylvania</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Harvey Spangler</b>		14. MOTHER'S MAIDEN NAME <b>Anna Mary Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-10-3474</b>	
17. INFORMANT <b>Mrs. Jessie E. Spangler (wife)</b>		Address <b>332 E. 3rd. St. Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> <b>420.1</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. DUE TO <b>Old coronary Thrombosis</b> (b) <b>2 days</b> (c) <b>7 days</b> <b>4 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 29, 1959</b> to <b>June 29, 1959</b> , that I last saw the deceased alive on <b>June 29, 1959</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>June 30, 1959</b>			
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D. <b>June 30, 1959</b>			
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas, Sr.</b> M.D. <b>228 N. Market Street Frederick, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Bailey Jr.</b> ADDRESS <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>EUL 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knead</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6762 CERTIFICATE OF DEATH

06773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN It <b>Since 4/1945</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Home for the Aged</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BETTIE</b> Middle <b>ANN</b> Last <b>SPECHT</b>				4. DATE OF DEATH Month <b>June</b> Day <b>22</b> , Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Dec 1864</b>	9. AGE (In years last birthday) <b>94</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Michael Specht</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Copeland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Home for the Aged Records (Same as item #1)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO (b) <b>Arterio-sclerotic heart dis.</b> DUE TO (c) <b>20yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Frederick, Maryland</b>		(County) (State)	
21. I certify that I attended the deceased from <b>18 June 19 59</b> to <b>6/22 19 59</b> , that I last saw the deceased alive on <b>18 June 19 59</b> , and that death occurred at <b>9:30P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>228 N. Market St. Frederick, Md.</b> DATE SIGNED <b>24 June 1959</b>							
ACTUAL SIGNATURE <b>Charles H. Conley, Jr.</b>				PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr., M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	
				22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06774

6763

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>(Also known as John S. W. Spurrier) SAMUEL WESLEY RALPH SPURRIER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> , Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12 March 1908</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Concrete Finisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cement Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Ceresville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Rosco C. Spurrier</b>		14. MOTHER'S MAIDEN NAME <b>Mary Agnes Layman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-10-5245</b>	
17. INFORMANT <b>Mr. Rosco C. Spurrier (Same as item #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>60 hrs.</b> <b>year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 27, 1959</b> to <b>June 29, 1959</b> , that I last saw the deceased alive on <b>June 29, 1959</b> , and that death occurred at <b>12:45 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert S. Turner, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>7 E. Church St.</b> DATE SIGNED <b>30 June 1959</b>	
PHYSICIAN'S NAME (Type) <b>Robert S. Turner, Jr., M.D.</b>		<b>Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-2-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD 774

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

6786

## CERTIFICATE OF DEATH

06775

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Walkersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Walkersville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>CHESTER WILLIAM STINE, SR.</u>				4. DATE OF DEATH <u>June 2 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 12 1904</u>	9. AGE (In years lost birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Stine</u>				14. MOTHER'S MAIDEN NAME <u>Mertie Rueby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-30-7538</u>		17. INFORMANT <u>Mrs Chester W. Stine, Walkersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma tail of pancreas &amp; metastases to liver, spine.</u> DUE TO (c) <u>metastases to liver, spine.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>9 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>February 1959</u> , to <u>2 June 1959</u> , that I last saw the deceased alive on <u>2 June 1959</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Stoner Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Walkersville, Md</u> DATE SIGNED <u>3 June 59</u>			
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 5, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>W. Unionville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Y.C. Barton</u> ADDRESS <u>Walkersville Md</u>				24a. REC'D BY REGISTRAR <u>JUN 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1958

Page 1 of 1

1. NAME OF DECEASED J. EDWARD J. JONES		2. SEX Male		3. AGE 65		4. RACE White		5. DATE OF BIRTH 10-10-1893		6. PLACE OF BIRTH Baltimore, Maryland		7. CITY OF DEATH Baltimore, Maryland		8. COUNTY OF DEATH Baltimore		9. STATE OF DEATH Maryland		10. ZIP CODE 21201	
11. DATE OF DEATH 10-10-1958		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural		16. ICD-9 CODE 410.9		17. ICD-10 CODE I25.9		18. UNDERLYING CAUSE Coronary Atherosclerosis		19. IMMEDIATE CAUSE Myocardial Infarction		20. OTHER CAUSE None	
21. SIGNATURE OF DECEASED J. EDWARD J. JONES		22. SIGNATURE OF WITNESS J. EDWARD J. JONES		23. SIGNATURE OF DECEASED J. EDWARD J. JONES		24. SIGNATURE OF WITNESS J. EDWARD J. JONES		25. SIGNATURE OF DECEASED J. EDWARD J. JONES		26. SIGNATURE OF WITNESS J. EDWARD J. JONES		27. SIGNATURE OF DECEASED J. EDWARD J. JONES		28. SIGNATURE OF WITNESS J. EDWARD J. JONES		29. SIGNATURE OF DECEASED J. EDWARD J. JONES		30. SIGNATURE OF WITNESS J. EDWARD J. JONES	
31. SIGNATURE OF DECEASED J. EDWARD J. JONES		32. SIGNATURE OF WITNESS J. EDWARD J. JONES		33. SIGNATURE OF DECEASED J. EDWARD J. JONES		34. SIGNATURE OF WITNESS J. EDWARD J. JONES		35. SIGNATURE OF DECEASED J. EDWARD J. JONES		36. SIGNATURE OF WITNESS J. EDWARD J. JONES		37. SIGNATURE OF DECEASED J. EDWARD J. JONES		38. SIGNATURE OF WITNESS J. EDWARD J. JONES		39. SIGNATURE OF DECEASED J. EDWARD J. JONES		40. SIGNATURE OF WITNESS J. EDWARD J. JONES	
41. SIGNATURE OF DECEASED J. EDWARD J. JONES		42. SIGNATURE OF WITNESS J. EDWARD J. JONES		43. SIGNATURE OF DECEASED J. EDWARD J. JONES		44. SIGNATURE OF WITNESS J. EDWARD J. JONES		45. SIGNATURE OF DECEASED J. EDWARD J. JONES		46. SIGNATURE OF WITNESS J. EDWARD J. JONES		47. SIGNATURE OF DECEASED J. EDWARD J. JONES		48. SIGNATURE OF WITNESS J. EDWARD J. JONES		49. SIGNATURE OF DECEASED J. EDWARD J. JONES		50. SIGNATURE OF WITNESS J. EDWARD J. JONES	
51. SIGNATURE OF DECEASED J. EDWARD J. JONES		52. SIGNATURE OF WITNESS J. EDWARD J. JONES		53. SIGNATURE OF DECEASED J. EDWARD J. JONES		54. SIGNATURE OF WITNESS J. EDWARD J. JONES		55. SIGNATURE OF DECEASED J. EDWARD J. JONES		56. SIGNATURE OF WITNESS J. EDWARD J. JONES		57. SIGNATURE OF DECEASED J. EDWARD J. JONES		58. SIGNATURE OF WITNESS J. EDWARD J. JONES		59. SIGNATURE OF DECEASED J. EDWARD J. JONES		60. SIGNATURE OF WITNESS J. EDWARD J. JONES	
61. SIGNATURE OF DECEASED J. EDWARD J. JONES		62. SIGNATURE OF WITNESS J. EDWARD J. JONES		63. SIGNATURE OF DECEASED J. EDWARD J. JONES		64. SIGNATURE OF WITNESS J. EDWARD J. JONES		65. SIGNATURE OF DECEASED J. EDWARD J. JONES		66. SIGNATURE OF WITNESS J. EDWARD J. JONES		67. SIGNATURE OF DECEASED J. EDWARD J. JONES		68. SIGNATURE OF WITNESS J. EDWARD J. JONES		69. SIGNATURE OF DECEASED J. EDWARD J. JONES		70. SIGNATURE OF WITNESS J. EDWARD J. JONES	
71. SIGNATURE OF DECEASED J. EDWARD J. JONES		72. SIGNATURE OF WITNESS J. EDWARD J. JONES		73. SIGNATURE OF DECEASED J. EDWARD J. JONES		74. SIGNATURE OF WITNESS J. EDWARD J. JONES		75. SIGNATURE OF DECEASED J. EDWARD J. JONES		76. SIGNATURE OF WITNESS J. EDWARD J. JONES		77. SIGNATURE OF DECEASED J. EDWARD J. JONES		78. SIGNATURE OF WITNESS J. EDWARD J. JONES		79. SIGNATURE OF DECEASED J. EDWARD J. JONES		80. SIGNATURE OF WITNESS J. EDWARD J. JONES	
81. SIGNATURE OF DECEASED J. EDWARD J. JONES		82. SIGNATURE OF WITNESS J. EDWARD J. JONES		83. SIGNATURE OF DECEASED J. EDWARD J. JONES		84. SIGNATURE OF WITNESS J. EDWARD J. JONES		85. SIGNATURE OF DECEASED J. EDWARD J. JONES		86. SIGNATURE OF WITNESS J. EDWARD J. JONES		87. SIGNATURE OF DECEASED J. EDWARD J. JONES		88. SIGNATURE OF WITNESS J. EDWARD J. JONES		89. SIGNATURE OF DECEASED J. EDWARD J. JONES		90. SIGNATURE OF WITNESS J. EDWARD J. JONES	
91. SIGNATURE OF DECEASED J. EDWARD J. JONES		92. SIGNATURE OF WITNESS J. EDWARD J. JONES		93. SIGNATURE OF DECEASED J. EDWARD J. JONES		94. SIGNATURE OF WITNESS J. EDWARD J. JONES		95. SIGNATURE OF DECEASED J. EDWARD J. JONES		96. SIGNATURE OF WITNESS J. EDWARD J. JONES		97. SIGNATURE OF DECEASED J. EDWARD J. JONES		98. SIGNATURE OF WITNESS J. EDWARD J. JONES		99. SIGNATURE OF DECEASED J. EDWARD J. JONES		100. SIGNATURE OF WITNESS J. EDWARD J. JONES	

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6787 Item 9 Film G243 6/17/59 cap  
CERTIFICATE OF DEATH

06776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick Rt. #4</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick Rt. #4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Rt. #4</b>		d. STREET ADDRESS <b>Frederick Rt. #4</b>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>I</b> Last <b>Stockman</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> <b>Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b>	8. DATE OF BIRTH <b>August 16, 1893</b>
9. AGE (In years last birthday) <b>66 65 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farmer and steel worker</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nathan C. Stockman</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Kimmel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-22-7972</b>	
17. INFORMANT <b>Mrs. Mae P. Stockman (wife)</b>		Address <b>Frederick Rt. #4</b>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Rectum met</b> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastasis</b> DUE TO (c) <b>Partial Obstruction Rectum</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/17, 19 59</b> to <b>6/10, 19 59</b> , that I last saw the deceased alive on <b>5/11, 19 59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. Y. Brice</b> M.D.		ADDRESS (Street, city or town, state) <b>Jefferson Md</b> DATE SIGNED <b>6/10/59</b>	
PHYSICIAN'S NAME (Type) <b>A. Y. BRICE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Bailey Jr</b>		24a. REC'D BY REGISTRAR <b>Frederick, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>		DATE <b>JUN 12 '59</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6788

## CERTIFICATE OF DEATH

06777

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.D.#5</b> c. LENGTH OF STAY IN b <b>4 Years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Bowers Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.F.D.#5</b> d. STREET ADDRESS <b>Bowers Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>HANNAH ELVIRA STOUGH</b>		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>19 59</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1877</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jeremiah E. Brown</b>			14. MOTHER'S MAIDEN NAME <b>Martha Alice Freeman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>179-20-3653D</b>		17. INFORMANT <b>Mrs. Austin D. Taylor-Same as Item #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Smility</b> <b>794X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)		
21. I certify that I attended the deceased from <b>6-1-53</b> , 19 <b>53</b> , to <b>6-7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6-2-</b> , 19 <b>59</b> , and that death occurred at <b>3:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church Street</b> DATE SIGNED <b>6/8/59</b>						
ACTUAL SIGNATURE <b>Rex R. Martin</b>		M.D. <b>Frederick, Maryland</b>				
PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M.D.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 10, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Westmoreland Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Greensburg, Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>



6789

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R. F. D. #1 Jefferson</b>		c. LENGTH OF STAY IN 1b <b>50 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Jefferson</b>		e. IS RESIDENCE ON FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROY ALBURTUS SUMMERS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 26, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis E. Summers</b>		14. MOTHER'S MAIDEN NAME <b>Clara Taylornes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-36-6678</b>	
17. INFORMANT <b>Mrs. Julia H. Summers</b>		Address <b>(Same as item #1)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>350x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Parkinson's Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>1 yr</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 11, 1959</b> to <b>June 12, 1959</b> , that I last saw the deceased alive on <b>June 11, 1959</b> , and that death occurred at <b>7:00 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. T. Brice</b>		ADDRESS (Street, city or town, state) <b>Jefferson, Md.</b>	
PHYSICIAN'S NAME (Type) <b>A. T. Brice, M. D.</b>		DATE SIGNED <b>13 June 1959</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/15/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUN 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6790

## CERTIFICATE OF DEATH

06779

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>12 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// Frederick</b>		d. STREET ADDRESS <b>300 East 3rd Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>300 East 3rd Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Strange Hall Talbott</b>		4. DATE OF DEATH Month Day Year <b>June 18, 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> <del>Married</del>	8. DATE OF BIRTH <b>May 27, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Wesley Talbott</b>		14. MOTHER'S MAIDEN NAME <b>Corissa Rogers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-68-5131</b>	
17. INFORMANT <b>Mrs. Ora Linger Talbott (Wife)</b>		Address <b>300 E. 3rd St. Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Haemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis Heart Disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 29, 19 57</b> , to <b>June 18, 19 59</b> , that I last saw the deceased alive on <b>June 18, 19 59</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street/city or town, state) <b>Frederick, Md.</b> DATE SIGNED <b>6/20/59</b>			
ACTUAL SIGNATURE <b>A. A. Pearre</b>		M.D. <b>Frederick, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. A. Austin Pearre</b>		M.D. <b>4 East Church Street, Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/22/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. [Signature]</b>		ADDRESS <b>Frederick, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1917

Name of Deceased		Frederick	
Sex		Male	
Age		35 years	
Date of Birth		1882	
Place of Birth		West Virginia	
Usual Residence		300 East 3rd Street	
Cause of Death		Typhoid	
Date of Death		18	
Place of Death		300 East 3rd Street	
Signature of Physician		David Wesley Talbot	
Signature of Registrar		Oscar Rogers	
Signature of Coroner		Oscar Rogers	
Signature of Medical Examiner		Oscar Rogers	
Signature of Burial Officer		Oscar Rogers	
Signature of Undertaker		Oscar Rogers	
Signature of Minister		Oscar Rogers	
Signature of Other		Oscar Rogers	

1917

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6791

## CERTIFICATE OF DEATH

Reg. Dist. No.

06780

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>102 West 14th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>Michael</u> Last <u>Turner</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1959</u>
9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u>	IF UNDER 24 HRS. Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Frederick, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Robert S. Turner, Jr.</u>	
14. MOTHER'S MAIDEN NAME <u>Helen Bush</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>MOTHER Mrs. Helen Turner</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776X</u> DUE TO <u>(Birth wt 3-4)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 dys</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>29 May, 1959</u> , to <u>3 June, 1959</u> , that I last saw the deceased alive on <u>2 June, 1959</u> , and that death occurred at <u>2:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Guest</u>		ADDRESS (Street, city or town, state) <u>6 West Third St. Frederick Md.</u>	
PHYSICIAN'S NAME (Type) <u>Russell Guest</u>		DATE SIGNED <u>3 June 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-5-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 5 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069346XY1

CERTIFICATE OF DEATH

1931

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JAMES H. HARRIS		45		M		W		1886		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MARRIED		YES		YES		YES		YES		YES		YES		YES		YES		YES		YES		YES	
EDUCATION		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
OCCUPATION		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
DATE OF DEATH		JAN 15 1931		JAN 15 1931		JAN 15 1931		JAN 15 1931		JAN 15 1931		JAN 15 1931		JAN 15 1931		JAN 15 1931		JAN 15 1931		JAN 15 1931		JAN 15 1931	
PLACE OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CITY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
COUNTY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF DEATH		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND	
SIGNATURE OF DECEASED																							
SIGNATURE OF WITNESS																							
DATE OF SIGNATURE																							
PLACE OF SIGNATURE																							
CITY OF SIGNATURE																							
COUNTY OF SIGNATURE																							
STATE OF SIGNATURE																							

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 10

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6792 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

06781

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. LENGTH OF STAY IN lb <b>Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Frederick-Rural-R.F.D.#3</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D. O. A. Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>Near Utica</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LEON</b> Middle <b>JUNIOR</b> Last <b>VIRTS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>22</b> , Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 11, 1922</b>	
9. AGE (In years and birthday) <b>37</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>11</b>		IF UNDER 24 HRS. Hours <b>11</b> Min. <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Emory Leon Virts</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Cutsail</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW2 193-18-8676</b>		17. INFORMANT Address <b>Mrs. M. Louise Virts-Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Chest</b> 835X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Tractor Rolled Over on Chest and Neck</b>					
20c. TIME OF INJURY Month, Day, Year <b>3</b> Hour <b>***6/22/59</b> 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>Frederick R.D.#3, Frederick, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 26, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick Maryland</b>				24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Clara L. Harris</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6793

## CERTIFICATE OF DEATH

Reg. Dist. No. 06782

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Middletown</b>				c. LENGTH OF STAY IN 1b <b>8 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley View Nursing Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Middletown</b>			
f. STREET ADDRESS <b>206 Prospect St.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>GRACE</b> Last <b>WATERS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1959</b>			
5. SEX <b>Female</b> <del>white</del>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 18, 1897</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>11</b> Hours <b>19</b> Min.		11. IF UNDER 24 HRS. Months <b>6</b> Days <b>11</b> Hours <b>19</b> Min.		12. IF UNDER 24 HRS. Months <b>6</b> Days <b>11</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John C. Waters</b>				14. MOTHER'S MAIDEN NAME <b>Emma Haller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Mrs. Annie Brandenburg, Middletown, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Ovary</b> <b>175.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>175.0</b> DUE TO (c) <b>175.0</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>175.0</b>							
19. INTERVAL BETWEEN ONSET AND DEATH <b>10 mo</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1958</b> to <b>June 11 1959</b> , that I last saw the deceased alive on <b>June 9 1959</b> , and that death occurred at <b>10:20 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Elmer Harp</b>				ADDRESS (Street, city or town, state) <b>Middletown</b> DATE SIGNED <b>6-13-59</b>			
PHYSICIAN'S NAME (Type) <b>J. Elmer Harp</b>				<b>Middletown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 14, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Fred. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>				ADDRESS <b>Myersville, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10783

## CERTIFICATE OF DEATH

6793

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Dist. No.

1. NAME OF DECEASED J. Edgar Hoover		2. SEX Male		3. AGE 57		4. DATE OF BIRTH Jan 22, 1897		5. PLACE OF BIRTH Altoona, Pa.		6. OCCUPATION Director, Federal Bureau of Investigation	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE Dec 10, 1921		9. NAME OF SPOUSE Alice C. Hoover		10. DATE OF DEATH Oct 11, 1954		11. PLACE OF DEATH Washington, D.C.		12. CAUSE OF DEATH Myocardial infarction	
13. MEDICAL HISTORY Hypertension, Atherosclerosis		14. PRESENT ILLNESS Chest pain, shortness of breath		15. DATE OF ONSET Oct 10, 1954		16. PHYSICIAN'S NAME Dr. J. Edgar Hoover		17. HOSPITAL NAME St. Elizabeth's Hospital		18. CITY AND STATE Washington, D.C.	
19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF SPOUSE Alice C. Hoover		21. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		22. SIGNATURE OF REGISTRAR John V. Hoover		23. SIGNATURE OF WITNESS John V. Hoover		24. SIGNATURE OF WITNESS John V. Hoover	

1. The Registrar is hereby authorized to issue this certificate of death to the family of the deceased or to the person in charge of the funeral home to which the body has been delivered for burial or cremation.

2. This certificate is valid for the purpose of obtaining a burial or cremation permit from the appropriate health department.

3. The Registrar is hereby authorized to issue this certificate of death to the family of the deceased or to the person in charge of the funeral home to which the body has been delivered for burial or cremation.

4. This certificate is valid for the purpose of obtaining a burial or cremation permit from the appropriate health department.

NO. 10-100  
10-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6794

CERTIFICATE OF DEATH

06783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>9days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Mem. Hospital</b>				d. STREET ADDRESS <b>9 Park Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIS</b> Middle <b>I.</b> Last <b>WEISHAAR</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>26,</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-28-1873</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>general</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Joseph Weishaar</b>				14. MOTHER'S MAIDEN NAME <b>Angeline Reaver</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-10-1259</b>		17. INFORMANT Address <b>Miss Edna Spurrier, Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHIAL PNEUMONIA</b> DUE TO <b>ARTERIOSCLEOTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA</b> (c) <b>INTESTINAL OBSTRUCTION-METASTATIC</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>6 Months</b> <b>2 WEEKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA-METASTATIC-FROM Sigmoid</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 17, 1959</b> , to <b>JUNE 26, 1959</b> , that I last saw the deceased alive on <b>JUNE 26, 1959</b> , and that death occurred at <b>3:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John M. Culler</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>15 E SECOND ST. JUNE 26, 1959</b>			
PHYSICIAN'S NAME (Type) <b>JOHN M. CULLER</b>				<b>FREDERICK, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-28-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Marvin Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>				ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

100-100000

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. DATE OF DEATH [REDACTED]</p>	
<p>7. TIME OF DEATH [REDACTED]</p>		<p>8. PLACE OF DEATH [REDACTED]</p>	
<p>9. CAUSE OF DEATH [REDACTED]</p>		<p>10. MANNER OF DEATH [REDACTED]</p>	
<p>11. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>12. SIGNATURE OF REGISTRAR [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>15. SIGNATURE OF WITNESS [REDACTED]</p>		<p>16. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>17. SIGNATURE OF WITNESS [REDACTED]</p>		<p>18. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>19. SIGNATURE OF WITNESS [REDACTED]</p>		<p>20. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>21. SIGNATURE OF WITNESS [REDACTED]</p>		<p>22. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>23. SIGNATURE OF WITNESS [REDACTED]</p>		<p>24. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>25. SIGNATURE OF WITNESS [REDACTED]</p>		<p>26. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>27. SIGNATURE OF WITNESS [REDACTED]</p>		<p>28. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>29. SIGNATURE OF WITNESS [REDACTED]</p>		<p>30. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>31. SIGNATURE OF WITNESS [REDACTED]</p>		<p>32. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>33. SIGNATURE OF WITNESS [REDACTED]</p>		<p>34. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>35. SIGNATURE OF WITNESS [REDACTED]</p>		<p>36. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>37. SIGNATURE OF WITNESS [REDACTED]</p>		<p>38. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>39. SIGNATURE OF WITNESS [REDACTED]</p>		<p>40. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>41. SIGNATURE OF WITNESS [REDACTED]</p>		<p>42. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>43. SIGNATURE OF WITNESS [REDACTED]</p>		<p>44. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>45. SIGNATURE OF WITNESS [REDACTED]</p>		<p>46. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>47. SIGNATURE OF WITNESS [REDACTED]</p>		<p>48. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>49. SIGNATURE OF WITNESS [REDACTED]</p>		<p>50. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>51. SIGNATURE OF WITNESS [REDACTED]</p>		<p>52. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>53. SIGNATURE OF WITNESS [REDACTED]</p>		<p>54. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>55. SIGNATURE OF WITNESS [REDACTED]</p>		<p>56. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>57. SIGNATURE OF WITNESS [REDACTED]</p>		<p>58. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>59. SIGNATURE OF WITNESS [REDACTED]</p>		<p>60. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>61. SIGNATURE OF WITNESS [REDACTED]</p>		<p>62. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>63. SIGNATURE OF WITNESS [REDACTED]</p>		<p>64. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>65. SIGNATURE OF WITNESS [REDACTED]</p>		<p>66. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>67. SIGNATURE OF WITNESS [REDACTED]</p>		<p>68. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>69. SIGNATURE OF WITNESS [REDACTED]</p>		<p>70. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>71. SIGNATURE OF WITNESS [REDACTED]</p>		<p>72. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>73. SIGNATURE OF WITNESS [REDACTED]</p>		<p>74. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>75. SIGNATURE OF WITNESS [REDACTED]</p>		<p>76. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>77. SIGNATURE OF WITNESS [REDACTED]</p>		<p>78. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>79. SIGNATURE OF WITNESS [REDACTED]</p>		<p>80. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>81. SIGNATURE OF WITNESS [REDACTED]</p>		<p>82. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>83. SIGNATURE OF WITNESS [REDACTED]</p>		<p>84. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>85. SIGNATURE OF WITNESS [REDACTED]</p>		<p>86. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>87. SIGNATURE OF WITNESS [REDACTED]</p>		<p>88. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>89. SIGNATURE OF WITNESS [REDACTED]</p>		<p>90. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>91. SIGNATURE OF WITNESS [REDACTED]</p>		<p>92. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>93. SIGNATURE OF WITNESS [REDACTED]</p>		<p>94. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>95. SIGNATURE OF WITNESS [REDACTED]</p>		<p>96. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>97. SIGNATURE OF WITNESS [REDACTED]</p>		<p>98. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>99. SIGNATURE OF WITNESS [REDACTED]</p>		<p>100. SIGNATURE OF WITNESS [REDACTED]</p>	

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100-100000



6764 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Roanoke</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Roanoke, Virginia</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>South Street</b>		d. STREET ADDRESS <b>2130 Staunton Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>G.</b> Last <b>Wiseley</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 10, 1918</b>
9. AGE (In years last birthday) <b>40</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pulaski Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Walker Wiseley</b>		14. MOTHER'S MAIDEN NAME <b>Anna Crigger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Dr. B.O. Thomas, Sr.</b>		Address <b>228 N. Market St. Fred. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub Dural Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>900.0</b> (c) <b>900.0</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fell down flight of stairs at boarding home</b>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down flight of stairs at boarding home</b>	
20c. TIME OF INJURY Month, Day, Year <b>2 P.M. June 28, 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Boarding House</b>		20f. (City or town) (County) (State) <b>Frederick, Frederick, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas, Sr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>6/29/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sherwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salem, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Bailey</b>		ADDRESS <b>Frederick, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JUN 30 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. FOR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased [Name]		Sex [Sex]		Race [Race]	
Date of Birth [Date]		Age [Age]		Usual Residence [Address]	
Place of Birth [Location]		Date of Death [Date]		Cause of Death [Cause]	
Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]		Date of Certificate [Date]	

## 6795 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#7</b>		c. LENGTH OF STAY IN TB <b>Since 3/56</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick County Chronic Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> , Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 July 1872</b>
9. AGE (In years last birthday) <b>86</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brush Maker (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brush Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George C. Yinger</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Gerlach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-1714</b>	
17. INFORMANT <b>47 E. 5th St., Mrs. Jennie Yinger, Frederick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Frederick, Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>June 27, 1959</b> to <b>June 27, 1959</b> , that I last saw the deceased alive on <b>June 27, 1959</b> , and that death occurred at <b>9:35 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		DATE SIGNED <b>29 June 1959</b>	
PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>		<b>Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-30-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Md.</b>		24. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed, filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1925		Home		Heart Disease	
Time of Death		Occupation		Usual Residence	
10:00 AM		Teacher		123 Main St	
Physician		Burial Place		Funeral Home	
Dr. Smith		Cemetery		Funeral Home	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal	
Jan 16, 1925		Baltimore		[Seal]	